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IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

BLUE CROSS/BLUE SHIELD OF CONNECTICUT,
Petitioner,
vs.
INTER VALLEY HEALTH PLAN,
Respondent.

PETITION FOR WRIT OF CERTIORARI
TO THE CALIFORNIA COURT OF APPEAL
FOURTH APPELLATE DISTRICT, DIVISION THREE

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. WHETHER A CALIFORNIA COURT MAY DISREGARD EXISTING FEDERAL COMMON LAW AND APPLY LOCAL STATE LAWS WHICH ARE PREEMPTED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1001, *et seq.*

II. WHETHER A UNIFORM RULE FOR ALL CO-ORDINATION OF BENEFIT DETERMINATIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1001, *et seq.*, SHOULD BE ADOPTED TO RESOLVE A SPLIT BETWEEN THE FEDERAL CIRCUIT COURTS.

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No. _____

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1993

BLUE CROSS/BLUE SHIELD OF CONNECTICUT,
Petitioner,
vs.
INTER VALLEY HEALTH PLAN,
Respondent.

PETITION FOR WRIT OF CERTIORARI

Petitioner Blue Cross/Blue Shield of Connecticut respectfully prays that a Writ of Certiorari issue to review a judgment of the California Court of Appeal, Fourth Appellate District, Division Three.

OPINIONS BELOW

The California Court of Appeal issued its opinion on May 27, 1993, published at 16 Cal.App.4th 60, 19 Cal.Rptr.2d 782, and is reproduced herein as Petitioner's Appendix A. The California Supreme Court denied review by an unpublished order on August 19, 1993, and appears herein as Appendix B. The trial court judgment and minute order filed January 24, 1992 are unpublished and appear herein as Appendix C.

JURISDICTION

This action presents a federal question arising under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* Both parties administer employee welfare benefit plans within the meaning of 29 U.S.C. § 1002(1). The action involves a dispute over payment of ERISA plan benefits.

After a trial on stipulated facts in California's Orange County Superior Court, respondent and plaintiff Inter Valley Health Plan appealed the judgment to the California Court of Appeal. On May 27, 1993, the Court of Appeal reversed the superior court judgment, holding that California insurance regulations were preempted by ERISA, but federal common law authorized the court to apply the local law of the forum state — California insurance regulations. Petitioner and defendant Blue Cross/Blue Shield of Connecticut filed a petition for review with the California Supreme Court, which was denied on August 19, 1993.

The United States Supreme Court has jurisdiction to review this case pursuant to 28 U.S.C. § 1257(a). By applying California insurance regulations to a self-funded employee benefit plan, the California Court of Appeal and California Supreme Court have drawn into question the validity of ERISA's preemption clause, 29 U.S.C. § 1144(a), and issued rulings which are repugnant to ERISA federal common law, as established by the Sixth, Seventh, and Ninth Circuit Courts of Appeals.

STATUTES AND REGULATIONS INVOLVED

29 U.S.C. § 1002(8):

The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

29 U.S.C. § 1132(e)(1):

Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

29 U.S.C. § 1144(a):

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. § 1144(b)(2)(A):

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(B):

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

10 Cal. Code Reg. § 1300.67.13(b)(4)(C):

In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

10 Cal. Code Reg. § 1300.67.13(b)(4)(D):

In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

10 Cal. Code Reg. § 1300.67.13(b)(4)(E):

In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules C. and D., the benefits of a Plan which covers the child as ~~a~~ dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

STATEMENT OF THE CASE

A. Factual Background.

Anjanette Farace incurred medical expenses for a bone marrow transplant and chemotherapy treatment. Each of her divorced parents' respective employee benefit plans provided coverage for these expenses. In fact, both plans paid for the treatment, leaving Children's Hospital of Orange County overpaid for the medical expenses in the amount of $511,000. The Hospital deposited this excess payment into the registry of California's Orange County Superior Court, and the mother's plan, Inter Valley Health Plan ("Inter Valley"), sued the father's plan, Saint Francis Hospital Health Plan ("Saint Francis"), and Blue Cross/Blue Shield of Connecticut ("Blue Cross"),[1] who administers the Saint

[1] All parties to this proceeding are listed on the caption of the case. Pursuant to Supreme Court Rule 29.1, Blue Cross names the following subsidiaries, which are not wholly owned: OMS, Inc. (a Massachusetts corporation); Signal Medical Services, Inc. (a Delaware corporation).

Francis plan, to determine which plan was primarily responsible for coverage.[2]

B. Procedural History.

After a trial of the case on stipulated facts, the superior court entered a judgment in favor of Blue Cross. The court concluded that ERISA preempted California insurance regulations[3] and, because ERISA is silent on the coordination of benefits issue, adopted the "birthday" rule as applicable federal common law in accordance with *PM Group Life Insurance Co. v. Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir. 1992). The birthday rule apportioned liability for primary coverage to Inter Valley, and thus entitled Blue Cross to a reimbursement of the overpaid medical benefits.

Respondent and plaintiff Inter Valley appealed the judgment and the California Court of Appeal reversed. Even though ERISA preempted state law, the state court of appeal held that the appropriate rule under ERISA is to defer to the law of California:

> While we conclude this case is governed by ERISA, we also conclude that because ERISA does not have a coordination of benefits provision the appropriate law under ERISA is to defer to the law of the forum state — here, California. And, under

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[2] The Saint Francis plan is a self-funded employee benefit plan administered by Blue Cross. Saint Francis purchased aggregate stop-loss insurance from Blue Cross, whereby the insurer agreed to reimburse Saint Francis "for the amount by which total paid claims for all participants in the Plan exceed certain specified limits."

[3] 10 Cal. Code Reg. §§ 1300.67.13(b)(4)(C-E).

> California law as it applies to divorced parents in light of Anjanette's parents' divorce decree, it is her father's plan that is primarily responsible for her health care expenses.

Inter Valley Health Plan v. Blue Cross/Blue Shield, 16 Cal.App.4th 60, 19 Cal.Rptr.2d 782, 784 (1993), *review denied* (Aug. 19, 1993).

REASONS FOR GRANTING THE WRIT

I.

WHETHER A CALIFORNIA COURT MAY DISREGARD EXISTING FEDERAL COMMON LAW AND APPLY LOCAL STATE LAWS WHICH ARE PREEMPTED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Certiorari should be granted in this case for two succinct reasons: (1) the state court of appeal invalidated ERISA's preemption clause by disregarding federal circuit court precedent and applying local regulations of the forum state; and (2) the split among the federal circuits must be resolved by adopting a uniform federal common law and thereby preventing future deviations by state courts.

A. The Court of Appeal Properly Concluded That ERISA Preempts California Insurance Regulations Which Relate To Each Parents' Respective Plan.

ERISA contains one of the most sweeping preemption clauses ever enacted by Congress. *PM Group*, 953 F.2d at 545. "The express preemption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.' " *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39 (1987), quoting, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, 101 S.Ct. 1895, 1906, 68 L.Ed.2d 402 (1981). The statute's legislative history reveals that ERISA was intended to preempt the entire field of employee benefit plans for federal regulation, thereby eliminating the threat of conflicting and inconsistent state and local regulations to employee benefit plans. *Pilot Life*, 481 U.S. at 46, 107 S.Ct. at 1552, citing, 120 Cong. Rec. 29197, 29933 (1974) [remarks of Senator Williams].

Given broad meaning, ERISA preempts state laws which indirectly and directly "relate to" employee benefit plans. *Shaw v. Delta Air Lines, Inc.*, 462 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983).[4] Preempted state laws include statutes as well as decisional law relating to employee benefit plans. *Simmons v. Diamond Shamrock Corp.*, 844 F.2d 517, 520 (8th Cir. 1988); *Jung v. FMC Corp.*, 755 F.2d 708, 714 (9th Cir. 1985). ERISA's savings clause excludes from preemption state laws which "regulate

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[4] *See* 29 U.S.C. § 1144(a).

insurance,"[5] but employee benefit plans shall not be "deemed" insurance companies for the purposes of ERISA's savings clause.[6] In other words, the deemer clause prevents the savings clause from becoming a rule-swallowing exception to ERISA preemption. *See FMC Corp. v. Holliday*, 498 U.S. 52, 64, 111 S.Ct. 403, 410-11, 112 L.Ed.2d 356 (1990).

Applying this framework, the state court of appeal properly concluded that ERISA preempts state coordination of benefits ("COB") regulations. *Inter Valley*, 19 Cal.Rptr.2d at 785. California's insurance regulations relate to the Inter Valley and Saint Francis employee benefit plans, but also qualify as laws which regulate insurance. *Id.* However, the Saint Francis plan is self-funded, and therefore ERISA's savings and deemer clauses do not displace the basic rule of preemption. *Id.*, citing, *FMC Corp.*, 482 U.S. at 60, 111 S.Ct. at 409.[7]

Having preempted the California insurance regulations, the state court of appeal resigned itself to searching for the appropriate law to apply. That search began and ended with the same California insurance regulations which the state court of appeal had just preempted.

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[5] *See* 29 U.S.C. § 1144(b)(2)(A).

[6] *See* 29 U.S.C. § 1144(b)(2)(B).

[7] A stop-loss insurance arrangement between a self-funded plan and an insurer does not change this result, for stop-loss insurer's reimburse the plan, not plan participants. *See United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986); *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922, 926-27 (9th Cir. 1985).

B. Courts Have Developed Federal Common Law To Resolve Disputes Between Competing ERISA Plans.

1. Where ERISA Is Silent On An Issue, Congress Intended For Courts To Fashion And Apply A Uniform Federal Common Law To Govern Employee Benefit Plans.

Given the sweeping preemptive force of ERISA, Congress was well aware and, in fact, intended for the judiciary to develop a uniform federal common law of rights and obligations to govern employee benefit plans. *Pilot Life*, 481 U.S. at 56, 107 S.Ct. at 1557; *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 954, 103 L.Ed.2d 80 (1989). The congressional goals of predictability and consistency which underlie ERISA's preemption clause are inextricably entwined with and demand a uniform federal common law:

> To require plan providers to design their programs in an environment of differing State regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.

FMC Corp., 498 U.S. at 60, 111 S.Ct. at 408. *See also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10, 107 S.Ct. 2211, 2216, 96 L.Ed.2d 1 (1987).

While a uniform federal common law will necessarily include established, well-reasoned state law precedents and scholarly treatises,[8] federal common law cannot merely serve as an invisible thread which haphazardly stitches together a patchwork quilt of individual state regulations. As the Ninth Circuit explained:

> Where . . . Congress expressly sweeps away state law, incorporation is far less appropriate: "It would make little sense to adopt a state law rule, which Congress has chosen to preempt, as a matter of federal common law."

PM Group, 953 F.2d at 546, quoting, *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1440 (9th Cir. 1990). Indeed, the entire *raison d'tres* of ERISA's preemption clause evaporates if courts may simply resort to local regulations under the artifice of federal common law.

2. Circuit Courts Have Formulated A Federal Common Law Rule To Govern COB Determinations For Employee Benefit Plans.

As the state court of appeal conceded, federal circuit courts have already spoken on the issue of COB determinations in ERISA plans. *Inter Valley*, 19 Cal.Rptr.2d at 786. The Ninth Circuit has adopted a law known as the "birthday" rule, which places primary liability on the plan of the employee whose birthday comes earlier in the year. *PM Group*, 953 F.2d at 547-48. *See also Reinforcing Iron Workers v. Michigan Bell Tel. Co.*, 746

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[8] For example, the *Firestone* opinion relied upon the Restatement (Second) of Trusts (1959) to formulate its rule. *Firestone*, 489 U.S. at 111-12, 115, 109 S.Ct. at 954-55, 957.

F. Supp. 668, 670-71 (E.D. Mich. 1990). By contrast, the Sixth and Seventh Circuits have adopted a "solomonic" approach to COB determinations. Under this rule, a court will attempt to reconcile each plan's COB provision, and if found to be mutually repugnant, liability will be apportioned on a pro rata basis. *Auto Club Ins. Ass'n. v. Health & Welfare Plans Inc.*, 961 F.2d 588, 594-95 (6th Cir. 1992); *Winstead v. Indiana Ins. Co.*, 855 F.2d 430, 433-34 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030, 109 S.Ct. 839, 102 L.Ed.2d 971 (1989).

Faced with these two clear choices of federal law, the California Court of Appeal opted for . . . neither.

C. The California Court Of Appeal Ignored Existing Federal Common Law And Applied The Local Law Of The Forum State.

After ruling that ERISA preempted California insurance regulations and identifying the controlling federal cases, the state court of appeal held that the cases were inapposite and the local regulations should be adopted as federal common law. *Inter Valley*, 19 Cal.Rptr.2d. at 788. In the view of the state court of appeal:

> [F]ederal law is not uniform, and is not going to be uniform until the United States Supreme Court finally decides the matter.

Inter Valley, 19 Cal.Rptr.2d. at 786. Since the Supreme Court has not ruled on this specific issue, the state court of appeal felt free to "rely on state law to fill in the gaps" Congress left in the ERISA statute. *Id.*, citing,

PM Group, 953 F.2d at 546.[9]

Notwithstanding existing federal circuit court decisions, the state court of appeal opined that California's insurance regulations come closest to a uniform federal rule, arguing that California follows recommendations by the Advisory Committee to the National Association of Insurance Commissioners ("NAIC"). Not so. "[T]he NAIC has advocated use of the birthday rule since 1984. [citation] Forty-two states now use the birthday rule." *PM Group*, 953 F.2d at 547, citing, Group Coordination of Benefits Model Regulation, Model Regulation Service (NAIC) at 120-15 to 120-20, 120-30 (Jan. 1991).[10]

Thus, a complete review of existing federal common law and applicable model state regulations exposes the state appellate court's feigned interest in uniformity and clear preference for local California regulations.

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[9] The state court of appeal failed to include *PM Group*'s entire analysis of the issue: where Congress chooses to preempt state law and preserve the entire field for federal regulation, incorporating individual state laws into ERISA federal common law leads to illogical and unintended results. *PM Group*, 953 F.2d at 546.

[10] The NAIC model rule limits the birthday rule exception for divorced parents to instances where specific terms of a divorce decree place financial responsibility for health care expenses for one parent *and* the insurer or plan has "actual knowledge" of that fact. Once benefits are paid by an insurer or plan without such knowledge of the decree, the existence of the decree is no longer relevant to determine the order of benefits for that claim. In this instance, Inter Valley paid without knowledge of the divorce decree and under the NAIC rule would still be liable for primary coverage. The California regulation inexplicably omits the "actual knowledge" requirement. *See Inter Valley*, 19 Cal.Rptr.2d at 787; *Superior Court Civil Minutes*, Appendix at C 7 [NAIC Model Rules for divorced parents would yield the same results].

D. The California Appellate Opinion Eviscerates Uniformity Within The Ninth Circuit and Creates Pernicious Opportunities For Parties To Engage In Forum Shopping.

After acknowledging that three federal circuit courts had formulated two comparable, but distinct rules of federal common law on point, the state court of appeal threw up its collective arms and declared that a uniform federal common law exists only in myth until the Supreme Court rules on the issue. *Inter Valley*, 19 Cal.Rptr.2d at 786. In doing so, the state court of appeal demonstrated a critical lack of foresight and indifference to the consequences of this published appellate decision.

First and foremost, California courts may now ignore federal circuit court decisions and apply local regulations to employee benefit plans under the guise of federal common law. Absent a Supreme Court decision to the contrary, the law of the forum state — California — will control, completely emasculating ERISA's preemption statute and resurrecting the inconsistency and unpredictability of conflicting state and local regulation which ERISA sought to eliminate when enacted. *See Pilot Life*, 481 U.S. at 46, 107 S.Ct. at 1552; *Shaw*, 463 U.S. at 98-99, 103 S.Ct. at 2901. Employee benefit plans situated in California with primary and secondary coverage liability will not know which rule to follow, *PM Group* or *Inter Valley*, and will naturally deny coverage if the issue presents itself, resulting in harm to plan participants, beneficiaries, and health care providers.

Furthermore, this published California opinion virtually requires parties to engage in forum shopping among state and federal courts upon whom ERISA confers

concurrent jurisdiction.[11] 29 U.S.C. § 1132(e)(1). Because a lawsuit filed or removed to a Ninth Circuit district court will produce the opposite result of a lawsuit filed or remanded to a California state court,[12] parties will undoubtedly resort to any and all procedural means of placing themselves before a forum most favorable to their position. Our judiciary should squelch these opportunities at every turn. *Cf. Salve Regina College v. Russell*, 499 U.S. 225, 233, 111 S.Ct. 1217, 1222, 113 L.Ed.2d 190 (1991).

The current conflict among the federal circuits is no excuse for adopting yet a different approach — applying the law of the forum state — nor for ignoring the powerful policies behind ERISA's preemption clause. The rule chosen by the state court of appeal creates a conflict within the Ninth Circuit, encourages parties to forum shop, undermines ERISA's legislative goals, increases litigation expenses, and will lead to unfair and disparate results.

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[11] "An opportunity for forum shopping exists whenever a party has a choice of forums that will apply different laws." *Ferens v. John Deere Co.*, 494 U.S. 516, 527, 110 S.Ct. 1274, 1281, 108 L.Ed.2d 443 (1990).

[12] For Example, federal jurisdiction may be unavailable if a defendant fails to secure joint removal from all other defendants. *See, e.g., Hewitt v. City of Stanton*, 798 F.2d 1230, 1232 (9th Cir. 1986); *Doe v. Kerwood*, 969 F.2d 165, 167, *reh'g denied*, 979 F.2d 1536 (5th Cir. 1992).

II.

WHETHER A UNIFORM RULE FOR ALL COORDINATION OF BENEFIT DETERMINATIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 SHOULD BE ADOPTED TO RESOLVE A SPLIT BETWEEN THE FEDERAL CIRCUITS.

A. As Evidenced By The California Appellate Opinion, State Courts Will Readily Apply The Law Of The Forum State Until The United States Supreme Court Resolves The Current Split Among The Circuits.

According to the rationale adopted by the state court of appeal, a "uniform" federal common law does not exist until the United States Supreme Court rules on an issue. *Inter Valley*, 19 Cal.Rptr.2d at 786. Because a split currently exists between the Sixth, Seventh, and Ninth Circuit Courts of Appeals, state appellate courts with concurrent jurisdiction apparently assume that they have a license to disregard existing federal common law and apply local statutes and regulations. To avoid future deviations by renegade state courts and protect the legislative intent of ERISA, the Supreme Court should grant certiorari in this case, adopt a uniform rule for COB determinations, and articulate specific criteria to be used in formulating federal common law.

B. Strong Policy Reasons Support Adoption Of A Birthday Rule To Determine The Order Of Benefits.

The Ninth Circuit Court of Appeals in *PM Group Life Insurance Co. v. Western Growers Assurance Trust, supra*, chose a hard and fast rule that could be applied without court intervention in every COB dispute. By adopting the birthday rule over other state regulations, the Ninth Circuit sought to "avoid the interpretative difficulties" caused by regulations such as California's[13] and eliminate the "confusion and expense" where states have inconsistent COB rules. *PM Group*, 953 F.2d at 547-48. Thus, the birthday rule adopted by *PM Group* embodies a clear preference for predictability, certainty, familiarity, and efficiency in making COB determinations.

The alternative "rule of solomon," adopted by the Sixth and Seventh Circuit Courts of Appeals, creates problems inconsistent with ERISA's legislative goals. The rule of solomon diminishes predictability and certainty since a court must always decree the results on an ad hoc basis; liability cannot be ascertained until the court determines that the COB provisions are mutually repugnant and apportions liability pro rata. Moreover, the precision and simplicity of the birthday rule is lost, given a court's ability and discretion to add several factors to its solomonic formula. Because this rule encourages employers to draft plans which place primary coverage on other employee benefit plans, equitable

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[13] The *PM Group* court found that California's COB provision lacked clarity, was internally inconsistent, led to perverse incentives, and included an obvious and significant typographical error. *PM Group*, 953 F.2d at 546.

COB provisions will disappear and solomon (the court) will always be called upon to decide those issues. See *Superior Court Civil Minutes*, Appendix at C 6. As the superior court reasoned in this case:

> The cost of such uncertainty, imprecision, and unpredictability will fall most heavily upon the ones whose interests should be primary — the plan beneficiaries, whose health care cost obligation will be disputed endlessly by the two (or more) plans involved. Secondary victims will be the health care providers, who may receive delayed payment for their services.

Id.

The birthday rule, as adopted by *PM Group* and the NAIC model regulations, incorporates a majority view and method that will be most familiar to and easily applied by employee benefit plans. As a result, COB disputes under ERISA will be placed firmly in the mainstream and promote national uniformity. *PM Group*, 953 F.2d at 547-48. In short, the Ninth Circuit has built a better mousetrap for COB determinations under ERISA, and the time has come for other courts to beat a path to its door.

C. In Accordance With ERISA's Statutory Definition Of A Plan Beneficiary, The Birthday Rule Does Not Attempt To Create Artificial Distinctions Between Beneficiaries Of Married And Divorced Parents.

Relying on California law, the state court of appeal justified its deviation from existing federal common law on the purported distinction between dependents of married and divorced parents:

> [B]ecause the instant case is one where the parties were divorced, the reason which prompted the Ninth Circuit to depart from the California regulations is not present here . . . *PM Group Life* did not deal with the child of divorced parents. The difference is substantively important. Absent agreement to the contrary, California law treats married couples as part of an ongoing economic partnership. [citations] In essence, a married couple is a single economic unit . . . This is obviously not the case with a divorced couple, who are two economic units. And, given the economic independence of a divorced couple, it makes far more sense for primary responsibility to follow the relationship which the parties themselves structure into their divorce judgment.

Inter Valley, 19 Cal.Rptr.2d at 787-88.[14]

This analysis is fundamentally flawed: individuals do not structure or modify employee benefit plans, rather the ERISA statute and employers retain authority for these benefit determinations. ERISA does not distinguish between beneficiaries of married or divorced plan participants, nor any other family relationships. "The term 'beneficiary' means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8). If a plan participant validly designates his or her child as a beneficiary, the marital and custody status of the child is immaterial. The inquiry taken by the state court of appeal attempts to develop a complicated hierarchy of benefit preferences beyond the control of the employer who has provided the benefits.[15] The distinction urged by the state court of appeal injects greater uncertainty and inefficiency into the federal legislative scheme aimed at eliminating precisely such a scenario.

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[14] As previously discussed, the court in *PM Group* departed from the California regulations and adopted the birthday rule primarily due to the policies underlying ERISA's preemption clause. *PM Group*, 953 F.2d at 547-48.

[15] Given the detailed analysis of the divorce decree and California law employed by the state court of appeal to determine which parent had assumed responsibility for Anjanette Farace's health care expenses, plan administrators cannot be reasonably expected to make COB determinations for nationwide plans in a consistent, cost-effective manner based upon California's purported distinction between beneficiaries from married and divorced couples. *See Inter Valley*, 19 Cal.Rptr.2d at 788-89.

CONCLUSION

The California Court of Appeal ran around ERISA preemption by substituting local administrative regulations for federal common law. The decision thwarts ERISA's goals, deviates from existing federal common law, creates opportunities for forum shopping, and reflects a conscious disregard for ERISA preemption. To repel these judicial breaches and resolve an existing split among the federal circuits, the Supreme Court should grant certiorari and clarify the standards for creating federal common law.

Dated: November 17, 1993.

GALTON & HELM

DANIEL W. MAGUIRE
Counsel of Record

MICHAEL F. BELL
MICHAEL HOFFMAN

Attorneys for Petitioner
Blue Cross/Blue Shield
of Connecticut

APPENDIX A

COURT OF APPEAL
FOURTH APPELLATE DISTRICT
DIVISION THREE

No. G012384
INTER VALLEY HEALTH PLAN,
Plaintiff and Appellant,
v.
BLUE CROSS/BLUE SHIELD OF CONNECTICUT,
Defendant and Respondent.

OPINION

MAY 27, 1993
(19 Cal. Rptr.2d 782)

SILLS, Presiding Justice.

The cost of Anjanette Farace's bone-marrow transplant and chemotherapy exceeded half a million dollars. Fortunately, she was covered by the health plans provided by each of her divorced parents' respective employers.

In fact, both plans — to their credit — paid for the treatment, leaving Children's Hospital of Orange County overpaid by some $511,000. The hospital deposited this money into the registry of the Orange County Superior Court, and the mother's plan, Inter Valley Health Plan, sued the father's plan, an employee medical plan administered by Blue Cross/Blue Shield of Connecticut (Blue Cross), to determine which plan was primarily responsible.

After a trial on stipulated facts and declarations submitted with the trial briefs, the court determined that the matter was governed by the federal employee

benefits law known as ERISA,[1] and, under ERISA, as interpreted by *PM Group Life Ins. v. Western Growers Assur. Trust* (9th Cir. 1992) 953 F.2d 543, the mother's plan was primary because her birthday comes earlier in the calendar year than the father's birthday (the birthday rule).

We reverse. *PM Group Life* did not involve divorced parents, and the distinction between a married couple and a divorced one is important in this context: a married couple is ordinarily one economic unit, a divorced couple is two. While we conclude this case is governed by ERISA, we also conclude that because ERISA does not have a coordination of benefits provision the appropriate rule under ERISA is to defer to the law of the forum state — here, California. And, under California law as it applies to divorced parents in the light of Anjanette's parents' divorce decree, it is her father's plan that is primarily responsible for her health care expenses.

I

We first tackle the question of whether this case is governed directly by ERISA or by state law. The preemption language in ERISA has been well explored in a series of federal decisions (e.g., *FMC Corp. v. Holliday* (1990) 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356; *Metropolitan Life Ins. Co. v. Mass.* (1985) 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728). The language is structured in three parts. First there is a broad

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[1] ERISA stands for the Employee Retirement Income Security Act of 1974. It has had a dramatic impact on employer-provided health plans. (See *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 [preemption of state common law causes of action].)

preemption clause, preempting state laws which "relate to any employee benefit plan."[2] Then there is a "saving clause" which excludes any state law which "regulates insurance" from the scope of the preemption clause.[3] Finally, there is "deemer" clause which, as a practical matter, carves out an exception to the saving clause by providing that employee benefit plans shall not be "deemed" insurance companies for purposes of the saving clause.[4]

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[2] "Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." (29 U.S.C. § 1144(a).)

This preemption clause has been described as "one of the broadest preeemption clauses ever enacted by Congress." (*Evans v. Safeco Life Ins. Co.* (9th Cir. 1990) 916 F.2d 1437, 1439.)

[3] "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." (29 U.S.C. § 1144(b)(2)(A).)

[4] "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." (29 U.S.C. § 1144(b)(2)(B).)

ERISA's convoluted structure on the preemption issue is not unlike that of an insurance policy. The preemption clause is analogous to an insuring clause, the saving clause to an exclusion, and the deemer clause plays the role of an exception to an exclusion. (But see *FMC Corp., supra*, 498 U.S. at p. 64, 111 S.Ct. at p. 411 ["We view the language of the deemer clause, however, to be either coextensive with or broader, not narrower, than that of the saving clause."].) For our purposes we need not press the comparison to determine whether the preemption clause should be like insuring clauses generally, construed "broadly" while the saving clause, like exclusions, should be construed "narrowly."

Accordingly, preemption under ERISA is tested under a three-step analysis: First, does the state law relate to an employee benefit plan? Second, does the state law regulate insurance? Third, may the plan be deemed an insurer under the state law? (See *Moore v. Provident Life & Acc. Ins. Co.* (9th Cir. 1986) 786 F.2d 922, 926.)

The California coordination of benefits regulations undoubtedly both "relate to" the employee benefit plans in this case and "regulate insurance." (See *Shaw v. Delta Air Lines Inc.* (1983) 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 [giving broad meaning to "relate to"] *PM Group Life, supra*, 953 F.2d at p. 546 ["Our only remaining question is whether California's coordination of benefits provision is a state insurance regulation. No doubt it is."].) The key issue is whether the father's plan is deemed an "insurance company."

For better or worse, the test laid down by the United States Supreme Court on the application of the deemer clause is whether the particular plan in question is self-funded. (*FMC Corp., supra*, 498 U.S. at p. 60, 111 S.Ct. at p. 409.) If so, the plan is governed by ERISA. On the other hand — and here is where it gets a little tricky — "employee benefit plans that are insured are subject to indirect state insurance regulation." (*Ibid.*) By "indirect regulation," the Supreme Court reveals that a state may regulate any insurer who issues a policy purchased by a plan: "Our interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contacts; if the plan is uninsured, the State may not regulate it." (498 U.S. at p. 64, 111 S.Ct. at p. 411.)[5] The Supreme Court did not go so far

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[5] Justice Stevens thinks the insured-uninsured distinction makes no sense. (See *FMC Corp., supra*, 498 U.S. at pp. 64-66, 111 S.Ct. at pp. 411-412 (dis. opn. of Stevens, J.) [distinction described as

(continued)

as to say that a state may directly regulate any plan that buys insurance for itself.

In the instant case, the father's plan is self-funded, but purchases aggregate stop-loss insurance.[6] The parties have stipulated that under the stop-loss arrangement the insurer reimburses the father's plan "for the amount by which total paid claims for all participants in the plan exceed certain specified limits."

The Ninth Circuit has already dealt with the question of whether ERISA governs employee benefit plans which, while self-funded, purchase stop-loss insurance policies. It does. (*United Food & Commercial Workers v. Pacyga* (9th Cir. 1986) 801 F.2d 1157, 1161-1162; *Moore v. Provident Life & Acc. Ins. Co., supra*, 786 F.2d at pp. 926-927.) While Inter Valley cites us contrary authority from the Sixth Circuit (*Northern Group Services v. Auto Owners Ins. Co.* (6th Cir. 1987) 833 F.2d 85, 91; *Michigan United Food and Commercial v. Baerwaldt* (6th Cir. 1985) 767 F.2d 308, 312-313), we believe *Pacyga* and *Moore* to be the better reasoned cases.

The Supreme Court did not set up a simple self-funded-equals-preempted, insured-equals-non-preempted dichotomy. State regulation reaches insured plans only "indirectly," as the regulation affects the insurance which the plans purchase. In this context, a state regulation making the plan itself — as distinct from a third party who insures it — primary over another plan would *directly* regulate the plan. The relationship between a

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(fn. continued)
"illogical," "irrational" (twice) and "anomalous"].)

[6] Anjanette's father was covered by a plan established in 1985 for employees of St. Francis Hospital and Medical Center, administered by Blue Cross. In addition, the stop-loss insurance was purchased under an agreement with Blue Cross.

health plan and its own insurer is not the same as that between a plan and another plan. Both *Pacyga* and *Moore* recognize the elementary fact that stop-loss insurers do not pay benefits directly to participants of the plan, but to the plan itself. (See *Pacyga, supra*, 801 F.2d at pp. 1161-1162; *Moore, supra*, 786 F.2d at pp. 926-927.)

II

However, it is one thing to determine that ERISA governs, another to figure out what ERISA would have us do. As *PM Group Life* notes, "ERISA does not include a coordination of benefits provision" to resolve primary-excess conflicts between parents' health plans. (953 F.2d at p. 546.)

At the outset, we must reject the notion that because *PM Group Life* used the birthday rule, we must apply it in the circumstances of this case. In adopting the birthday rule, *PM Group Life* first rejected the idea of adopting the law of the forum state. Reasoning from the broad preemption provision in ERISA, the *PM Group Life* court focused primarily on the need to adopt a *uniform* federal rule under ERISA, and secondarily on the textual obscurity of the applicable California insurance regulations. (See 953 F.2d at pp. 546-547.)

These considerations are not persuasive here. First, federal law is not uniform, and is not going to be uniform until the United States Supreme Court finally decides the matter. *PM Group Life* does not appear to have been aware of cases from the Sixth and Seventh Circuits which adopted an approach altogether different from the birthday rule. (See *Auto Club Ins. v. Health and Welfare Plans* (6th Cir. 1992) 961 F.2d 588, 594-595; *Winstead v. Indiana Ins. Co.* (7th Cir. 1988)

855 F.2d 430, 433-434.)[7] These cases first try to reconcile the coordination of benefit provisions in the respective plans, and then, if those provisions are mutually exclusive, apportion responsibility pro rata. Because this approach amounts, as it were, to dividing the baby in half, it has been termed "solomonic." (See *Winstead, surpa*, 855 F.2d at p. 434.)

Second, however convoluted and self-contradictory the California regulations concerning the children of *non*divorced parents may be, the regulations are reasonably straightforward where the children of divorced parents are concerned.[8] Parallel provisions in Title 10 California Code of Regulations sections 1300.67.13(b)(4)(C) through (E) and sections 2232.56(d)(3) through (5) set out the "order of benefit determination" of overlapping health benefit plans.

The basic rule is that plan responsibility follows custody. Where the parents are divorced and the parent with custody has not remarried, sections 1300.67.13(b)(4)(C) and 2232.56(d)(3) make primary the plan of the parent with "custody."[9] Where the parents are

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[7] On pages 547 to 548 of the opinion, the *PM Group Life* court mentions a district court case from Michigan as the "one other court that has addressed the issue."

Interestingly enough, the trial judge in the present case also noted the omission of any mention of *Winstead* in the *PM Group Life* decision.

[8] When *PM Group Life* quoted Title 10 California Code of Regulations section 2232.56(d)(2) to show that California is trying (though perhaps not too clearly) to adopt the birthday rule, the court omitted the introductory words, "Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced. . . ." (See 953 F.2d at p. 546, fn. 4.)

[9] The text of Title 10 California Code of Regulations section 1300.67.13(b)(4)(C) and section 2232.56(d)(3) is: "In the case of a person for whom claim is made as a dependent child whose parents

(continued)

divorced and the parent with custody *has* remarried, sections 1300.67.13(b)(4)(D) and 2232.56(d)(4) make primary first the plan of the parent with custody, next the plan of the stepparent, and then finally the plan of the parent without custody.[10] Finally, sections 1300.67.13(b)(4)(E) and 2232.56(d)(5) allow the previous two rules to be overridden where "there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child." In such a case, the primary plan is the one "of the parent with such financial responsibility."[11] These regulations do not have the

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(fn. continued)
are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody."

[10] The text of Title 10 California Code of Regulations section 1300.67.13(b)(4)(D) and section 2232.56(d)(4) is: "In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which cover that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody."

[11] The text of Title 10 California Code of Regulations section 1300.67.13(b)(4)(E) is: "In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules C. and D., the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefit of any other Plan which covers the child as a dependent child." Section 2232.56(d)(5) is the same, except it substitutes the words "paragraphs (3) and (4) above" for "rules C. and D."

self-contradictory element that discouraged the court in *PM Group Life* from following the law of the forum state. (See 958 F.2d at p. 547, fn. 4 ["So construed, section 2232.56(d)(2) contradicts itself by giving preference to plans that fail to follow it."].)

The basic order set out in the California regulations follows the sequence recommended by the Advisory Committee to the National Association of Insurance Commissioners (NAIC), whose 1985 report has been included in the record. That is, if the parents are not divorced or separated, the birthday rule should be used. If the parents are divorced or separated, the order of health insurer is first that of the parent with custody, then the spouse of the parent with custody, then the noncustodial parent, except where "the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms." In such an event that plan pays first. The basic difference between the California regulations and the NAIC approach is that in cases where the parents are not divorced or separated, the California regulations add an unnecessarily mysterious sentence which arguably appears to allow a plan to depart from the birthday rule.[12] In any event, because the instant case is one where the parents were divorced, the reason which prompted the Ninth

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[12] Here is the sentence, quoted from *PM Group Life*, 953 F.2d at page 547, footnote 4: "If either plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of benefits." We will not attempt an English translation.

Circuit to depart from the California regulations is not present here.

This last point bears elaboration. *PM Group Life* did not deal with the child of divorced parents. The difference is substantively important. Absent agreement to the contrary, California law treats married couples as part of an ongoing economic partnership. (E.g., *In re Marriage of Worth* (1987) 195 Cal.App.3d 768, 773, 241 Cal.Rptr. 135; *Johns v. Retirement Fund Trust* (1981) 117 Cal.App.3d 113, 116, 172 Cal.Rptr. 541; *In re Marriage of Brigden* (1978) 80 Cal.App.3d 380, 389, 145 Cal.Rptr. 716.) In essence, a married couple is a single economic unit. Accordingly, there is a reason to draw an arbitrary line as to which health insurer has primary responsibility as between a married couple. The birthday rule, in such a context, is the analytic equivalent of flipping a coin.

This is obviously not the case with a divorced couple, who are two economic units. And, given the economic independence of a divorced couple, it makes far more sense for primary responsibility to follow the relationship which the parties themselves structure into their divorce judgment.

Accordingly, we do not believe that *PM Group Life's* birthday rule controls this case. The question remains, however — what is the appropriate rule under ERISA?

As mentioned, while the preemption provisions of ERISA are broad, there is no provision directly on point. In light of our discussion above, and the fact, recognized by *PM Group Life*, that "[f]ederal courts often rely on state law to fill the gaps Congress leaves in federal statutes" (953 F.2d at p. 546), the gap should be supplied by the state regulations, particularly where, as here, those regulations follow the national pattern.

The first question that arises in applying the state regulations pertaining to cases where the parents are divorced is the word "custody." Anjanette's mother and father were each given joint "legal" custody of her, but her mother has had sole "physical" custody.

In determining the intent of lawmakers, courts look first to the words of the provision, giving those words their "usual and ordinary meaning." (Cf. *People v. Hull* (1991) 1 Cal.4th 266, 271, 274-275, 2 Cal.Rptr.2d 526, 820 P.2d 1036; *City of Santa Cruz v. Municipal Court* (1989) 49 Cal.3d 74, 90, 260 Cal.Rptr. 520, 776 P.2d 222.) The principle also applies to regulators. "Administrative regulations are subject to the same rules of construction and interpretation that apply to statutes." (*Organization of Deputy Sheriffs v. County of San Mateo* (1975) 48 Cal.App.3d 331, 341, 122 Cal.Rptr 210.)[13]

While custody can have a specialized meaning under the Family Law Act (see Civ.Code, § 4600.5, subd. (d)(5)),[14] it is not the ordinary meaning of the word. The ordinary meaning of "custody" in the context of a child of divorced parents is *physical* custody — the parent with whom the child actually lives. Accordingly, we conclude that under California law, the Code of Regulations makes the mother's plan primary *unless* "there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child." (See Title 10 Cal.Code of Regulations, §§ 1300.67.13(b)(4)

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[13] We are not aware of any specialized meaning of "custody" given the word by the administrative agency involved with the implementation of the statute.

[14] The statute reads: " 'Joint legal custody' means that both parents shall share the right and the responsibility to make the decisions relating to the health, education, and welfare of a child."

(E) and 2232.56(d)(5).)[15]

This brings us to the divorce judgment between Anjanette's parents, filed in April 1983 in Los Angeles Superior Court. The document provides that her father "shall maintain all of the parties' children as beneficiaries of any health and dental care insurance policies he may now have or may be able to obtain through his employment. . . ." It also provides that each party shall pay half the cost of orthodontic care, and half the cost of existing and future accounts with a certain dental group in West Covina or "such other dental bills as the children may incur." The judgment does not directly address the question of who is responsible for medical and health care expenses (other than dental expenses) not otherwise covered by health insurance.

And so this case boils down to one question: does the court decree obligating Anjanette's father to maintain her as a beneficiary on any health plans he then had or "may be able to obtain through his employment" constitute "a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child?"

We recognize there is nothing in the judgment of dissolution which assigns to Anjanette's father the responsibility to pay all her medical expenses when they are not otherwise covered by health insurance. Indeed, in the absence of health insurance, both parents would bear responsibility. (Civ.Code, § 4720, subds. (a)(3)(B) and (a)(3)(D); see also *Carr v. Marshman* (1983) 147 Cal.App.3d 1117, 1121, 195 Cal.Rptr 603 ["a decree of

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[15] The California insurance regulations do not address the case of actual joint physical custody, i.e., where a child spends equal time with each parent. Joint physical custody is not present in the case before us, and, accordingly, we do not address the question of which plan — or plans — would be primary if it were.

dissolution which requires one parent alone to support the children does not abrogate the duty of the other parent to support those children"]; Hogoboom & King, Cal. Practice Guide: Family Law (Rutter 1993) § 6:2 ["Each parent has an 'equal responsibility' to support their minor children 'in the manner suitable to the child's circumstance. . . .' "].)[16] If, for some reason, Anjanette's father found himself in a job which did *not* offer "any" health insurance at all, he could hardly be held in contempt for failing to "maintain" Anjanette on that nonexistent insurance.

However, it is precisely the imposition on both parents of responsibility for uncovered health expenses that shows the parties contemplated that "financial responsibility" for Anjanette's medical expenses would rest with her father's health plan — at least as long as he had the opportunity for a health plan "through employment." The parents could not have diminished their own collective responsibility toward Anjanette by means of an agreement, but they could try to make sure that one of them would take the necessary steps to have an insurer assume financial responsibility for Anjanette's health care costs. The provision in the judgment requiring Anjanette's father to maintain his present health insurance and obtain health insurance if offered "through employment" was as much as they could do, as between themselves, to "establish" financial responsibility with the father's insurer.

Significantly, the judgment of dissolution puts no limits on Anjanette's father's obligation to "maintain" her on his then-present health insurance, or on "any" insurance that might be available "through employment"

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[16] We do not address the nature of the responsibility as between the two parents, e.g., whether it is equal, or based on principles of joint and several liability or some other standard.

in the future. If his then-present or future employer required, say, a large employee contribution to "maintain" the children as dependents on the plan, Anjanette's father would have had to pay it under the terms of the judgment. In fact, the words "any," "through employment" and "able to obtain" show that even if an employer simply made a health plan available "through employment" with *no* employer contribution, Anjanette's father would have been obligated to sign up for it and pay any payroll deduction required. Thus the requirement that Anjanette's father "maintain" then-present health insurance envisioned at least some *substantive* obligation on his part to obtain health insurance, and was not solely a matter of guaranteeing the continued existence of what might simply be a *gratuitously* provided benefit. Construing the dissolution decree in this case, we must conclude that the parents structured it so that the father's health plan (if one was available through employment) would assume financial responsibility for Anjanette's health care expenses.

III

Under ERISA, as incorporating the law of the forum state, the father's plan, and not the mother's plan, is the primary one. We must therefore reverse the judgment of the trial court, and direct that a new one be entered declaring the father's plan, Blue Cross, as the primary insurer for the services provided to Anjanette by Children's Hospital of Orange County, and that the funds deposited shall be paid to Inter Valley. In the interests of justice both parties will bear their own costs on appeal.

MOORE and SONENSHINE, JJ., concur.

APPENDIX B

Fourth Appellate District, Division Three, No. G012384
S033679

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

IN BANK

SUPREME COURT
FILED
AUG 19 1993
Robert Wandruff Clerk
Deputy

INTER VALLEY HEATH PLAN,
Appellant
v.
BLUE CROSS/BLUE SHIELD
OF CONNECTICUT,
Respondent

Respondent's petition for review DENIED.

KENNARD
Acting Chief Justice

APPENDIX C

SUPERIOR COURT OF THE
STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

INTER VALLEY HEALTH PLAN,
a California non-profit corporation,

Plaintiff,

vs.

CHILDREN'S HOSPITAL OF ORANGE COUNTY, a California non-profit corporation; ST. FRANCIS HOSPITAL MEDICAL CENTER, a non-profit corporation; BLUE CROSS/BLUE SHIELD OF CONNECTICUT, a non-profit corporation; and DOES 1 through 50, inclusive,

Defendants.

CASE NO.: 613 465

DIFFERENTIAL CASE MANAGEMENT PROGRAM

JUDGE RONALD L. BAUER
DEPARTMENT 23

JUDGMENT AFTER TRIAL BY
SUPERIOR COURT

This cause came on regularly for court trial on January 10, 1992, in Department 23 of the above entitled court, the Honorable Ronald L. Bauer, Judge, presiding, sitting without a jury. Plaintiff and cross-defendant

INTER VALLEY HEALTH PLAN appeared by its attorney Julie McCoy Akins of Stradling, Yocca, Carlson & Rauth. Defendant and cross-complainant BLUE CROSS/BLUE SHIELD OF CONNECTICUT appeared by its attorney Michael F. Bell of Galton & Helm. Evidence having been presented by both parties through stipulated facts and declarations, the cause having been argued and submitted for decision, and the court having issued its Minute Order filed January 24, 1992,

IT IS ORDERED, ADJUDGED, AND DECREED THAT:

1. In accordance with the Court's Minute Order filed January 24, 1992 attached hereto as Exhibit "A" and incorporated herein, plaintiff and cross-defendant INTER VALLEY HEALTH PLAN is the primary insurer for the health care services provided to Anjanette Farace by Childrens Hospital of Orange County;

2 The funds in the amount of $511,009.00, and any accrued interest thereon, deposited by Childrens Hospital of Orange County with this court shall be paid to defendant and cross-complainant BLUE CROSS/BLUE SHIELD OF CONNECTICUT; and

3. BLUE CROSS/BLUE SHIELD OF CONNECTICUT, as the prevailing party, is awarded its costs from plaintiff and cross-defendant INTER VALLEY HEALTH PLAN.

DATED:

HONORABLE RONALD L. BAUER
JUDGE OF THE SUPERIOR COURT

Approved as to form:

STRADLING, YOCCA, CARLSON
& RAUTH

/s/ JULIE MCCOY AKINS
By: JULIE MCCOY AKINS
Attorneys for INTER VALLEY
HEALTH PLAN

GALTON & HELM

/s/ MICHAEL F. BELL
By: MICHAEL F. BELL
Attorneys for
BLUE CROSS/BLUE SHIELD
OF CONNECTICUT

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

Inter Valley Health Plan
Plaintiff/Petitioner
vs.
Children's Hospital of
Orange County
Defendant/Respondent

Case Number 61-34-65

CERTIFICATE OF
SERVICE BY
MAIL OF

I, GARY L. GRANVILLE, County Clerk, and Clerk of the Superior Court, in and for the County of Orange, State of California, hereby certify that I am not a party to the within action or proceeding that on January 24, 1992, I served the copy of minute order on each of the parties hereinafter named by depositing a true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States Postal Service mail box at Santa Ana, California addressed as follows:

Michael Bell
Galton & Helm
500 South Grand Ave.
Suite 1200
Los Angeles, Ca. 90071

Julie McCoy Akins
Stradling, Yocca, Carlson
& Rauth
660 Newport Center Drive
Suite 1600
Newport Beach, Ca. 92660

Dated: January 24 1992

GARY L. GRANVILLE
County Clerk and Clerk of the Superior Court
in and for the County of Orange,
By: /s/ Joan Ashworth
Deputy

CERTIFICATE OF SERVICE OF MAIL

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

Dept. 23

Court convened at _____ M. January 23, 1992, present Hon. Ronald L. Bauer, Judge; Joan Ashworth, Deputy Clerk; none, Bailiff; none, Reporter; and the following proceedings were had:

61 34 65 INTER VALLEY HEALTH PLAN vs.
CHILDREN'S HOSPITAL OF ORANGE COUNTY

In response to the First Amended Complaint and the Cross-Complaint herein, filed respectively on behalf of Inter Valley Health Plan and Blue Cross/Blue Shield of Connecticut, the court declares that plaintiff is the primary insurer for the health care services provided to Anjanette Farace by Children's Hospital of Orange County. The funds previously deposited with this court by Children's Hospital shall be paid to Blue Cross/Blue Shield of Connecticut. The "birthday rule," which will be applied here, dictates this result.

Much of the authority cited by both parties to this dispute comes from federal courts. The force and effect of such opinions is discussed in *Alicia T. v. County of Los Angeles*, (1990) 222 Cal.App.3d 869, 879. That rule seems to leave this court some discretion to select from conflicting decisions or lines of authority in the federal courts or perhaps even to fashion a new and different rule, since "the decisions of the lower federal courts, although entitled to great weight, are not binding on state courts." Such inventiveness will not be required here, however, since there is ample cogent authority to support the conclusion set forth above.

The case of *FMC Corp. v. Holliday* (1990) 111 Sup.Ct. 403 indicates that state insurance statutes or regulations may not be applied to the present dispute. As the St. Francis plan is self-funded, the saving and the deemer clauses in ERISA will not here displace the basic rule of preemption.

While it is puzzling that the opinion in *PM Group Life Ins. Co. v. Western Growers Assurance Trust* (9th Cir. 1992) 92 D.A.R. 354 made no mention of the prior case of *Winstead v. Indiana Ins. Co.* (7th Cir. 1988) 855 F.2d 430, this court has concluded that *PM*'s birthday rule should be applied here. It has the virtues described in the *PM* opinion, as well as some advantages perhaps not fully addressed there. The Solomon rule diminishes desired predictability, as its results must always be decreed on an ad hoc basis. Nor can that rule promote precision or simplicity, as the fifty-fifty result in *Winstead* may not be applied by another Solomon who finds that several more factors should be added to the formula. Meanwhile, authors of plans will be encouraged to prescribe that the "other" coverage will always be primary, and no one will try to write a fair COB provision. Thus, Solomon will always be called upon to decide those issues.

The cost of such uncertainty, imprecision, and unpredictability will fall most heavily upon the ones whose interests should be primary — the plan beneficiaries, whose health care cost obligation will be disputed endlessly by the two (or more) plans involved. Secondary victims will be the health care providers, who may receive delayed payment for their services. While the litigants in the present case are to be commended for their apparently prompt — and duplicate — payment for the services rendered to Anjanette Farace, that is surely an exceptional circumstance, and it would probably never occur if the unpredictable Solomon rule were in

place. Repeated litigation would be an automatic result of such a rule. The birthday rule instead substitutes a certain result.

While the *PM* opinion suggests that the birthday rule should be applied in all cases, even with divorced or separated parents, the NAIC Model Rules for divorced parents would yield the same result in the present case. Barbara has custody of Anjanette, and her plan would be primary. No exception to that rule applies here.

Counsel for Blue Cross/Blue Shield of Connecticut is directed to prepare an appropriate judgment, submit it to opposing counsel for review, and then send it to the court for execution.

A copy of this minute order was sent to the counsel present for this hearing. The moving party is to give notice to any/all other parties that are given notice of this hearing.